Technical Review Questions from the Public Hearing—Deb Schardt

1. Thirty Three states define direct supervision as, " a licensed dentist is present in the office, personally diagnoses the condition to be treated, has personally authorized the procedures, remains in the office while the procedures are being performed and evaluates the performance of the Dental Assistant before the dismissal of the patient." **These states include: Alabama; Alaska; Arkansas; Delaware; District of Columbia; Florida; Georgia; Hawaii; Idaho; Illinois; Kansas; Kentucky; Louisiana; Maine; Maryland; Michigan; Minnesota; Mississippi; Missouri; New Hampshire; New Mexico; New York; North Carolina; North Dakota; Ohio; Oklahoma; Pennsylvania; Rhode Island; South Carolina; South Dakota; Tennessee; Virginia; Wyoming.** (taken from the Dental Assisting National Board, 2012)

2. Outcome measures. There are no universal state regulations that require dental hygienists to report practice data. Limited research and anecdotal information demonstrate that direct access care has facilitated alternate entry points into the oral health systems for thousands of previously un-served and underserved Americans. Older adults, persons with special needs, children in schools, pregnant women, minority populations, rural populations and others have benefited from the availability of services provided by direct access dental hygienists. Expanding the services allowed would only enhance the care provided to these population groups. (Reference: "Expanding Oral Care Opportunities: Direct Access Care Provided by Dental Hygienists In The United States" by Doreen K. Naughton, RDH, BSDH) Also refer to the I-Smile data from Iowa and the report, " Early Impacts of Dental Therapists in Minnesota") Nebraska data was also submitted earlier on the TR website in a program that was grant funded and served nearly 14,000 patients from January 2011 through August of 2012

3. The NDHA finds it interesting that of those who have testified **against** the NDHA proposal or submitted written testimony in opposition, only **one** pediatric dentist and **two** newly graduated dentists even see new Medicaid clients. The rest of the dentists or specialty groups will **not even see a new Medicaid patient**. This seems to be counterintuitive to the reason these proposals were submitted, to improve **ACCESS to CARE.** I find it difficult to fathom that those who are not seeing Medicaid will all of a sudden start seeing them, as well as help to facilitate these client's transportation concerns to get to their dental offices.

4. Public Health Dental Hygienists scope of practice is limited to seeing only those clients that are in a public health setting or in a health care or related facility. Healthcare or related facility means a hospital, a nursing facility, an assisted-living facility, a correctional facility, a tribal clinic, or a school-based preventive health program; and public health setting means a federal, state, or local public health department or clinic, community health center, rural health clinic or other similar program or agency that serves primarily public health care program recipients. By allowing the enhanced procedures in the Dental Hygiene Proposal this would only enhance the services these clients are able to access and to be able to live and achieve the activities of daily living.

5. Permit me to share a public health success story with you. I recently saw a child in a Head Start clinic that I was doing in a local school. This child had already had 4 of his upper front teeth removed due to decay. He had teeth that were decayed down to the gum line with two abscessed teeth. This child did his best to cover this up as he did not want to eat or brush his teeth due to the pain. After being identified and working with a grandparent to get him to the Mission of Mercy that was occurring, this child was finally able to get care. Recently, I had the privilege to see him again and his entire demeanor was changed. He still had more teeth that were removed, and a couple of crowns placed, but the infection was gone. For public health dental hygienists, this is what makes our mission so rewarding. It is not just recognizing, but finding care, and providing transportation to children to get much needed services.

6. In comparing these proposals with what the nursing model looks like, the NDHA proposal recommends additional **formal** education for **licensed** dental hygienists to perform **limited** additional duties that are performed by dentists currently,(similar to a an Advanced Practice Nurse) as well as allowing the dental hygienist to **utilize their full scope of practice in alternative settings, just as an RN currently is allowed to do.** This model has worked in the medical community for years. We don't have certified nurse aides (CNA) doing procedures that only a physician does, we utilize the advanced practice nurse who has the formal education and licensure from an accredited institution to provide these services. You may also allow a CNA to provide some additional functions with the required education (**like the NDHA proposal recommends**). CNA's also have **required education and certification** in order to work or provide services in any setting. This is not true of dental assistants. **Physicians do not delegate duties to an unqualified individual who does not hold a credential to perform such duties, nor is the physician's regulating board allowed to determine what the CNA can or cannot do and with or without education.**

Within the medical community there are inspections and standard of care requirements that need to be met. Dentistry does not have routine inspections so if there are breaches in standard of care, it may not be found out until there is significant harm done to a patient. This is concerning to NDHA that a **standard of care model is not mandated** in the dental field.

7. In addition, the NDA/NDAA proposal wants everything to be decided by the Board of Dentistry, which is made up mostly of dentists who change throughout the course of time allowing for **inconsistency in educational requirements**. Educational requirements are outlined in statute for dentists and dental hygienists and this is where it is critical to have the same measures in **statute** for the educational requirements for dental assistants to assure standard of care and competency testing.

   The NDHA proposal is a reasonable means to expand the scope of practice of both dental hygienists and dental assistants. This proposal uses the existing workforce of dental hygienists and dental assistants and the existing education and accredited training programs available to both. The model allows those dentists who wish to delegate more to their clinical staff, the ability to do so. The model aligns appropriate supervision with the delegated duties. Finally, the model balances the need for education and credentialing while at the same time not overly regulating any one profession.

   In summary, the proposed model is a responsible means for serving the Medicaid, underserved and unserved population in Nebraska who has difficulty finding dental care. The NDHA model allows dental clinics to operate more efficiently, thus potentially increasing their capacity to care for more Medicaid, underserved and unserved populations. Finally, the proposed model is an expanded model of care that will more effectively and efficiently serve *all* Nebraskans who receive dental services.